

Birch Tree Communities, Inc.

Admissions Info Sheet

Admissions Department Contact

Sarah Testa, LCSW, Admissions Director 501-303-3109 office | 501-631-3794 fax

sarah.testa@birchtree.org

Send referrals to sarah.testa@birchtree.org OR fax to 501-631-3794

Birchtree.org/admissions

Birch Tree Communities, Inc. is a community-based program which provides housing and day treatment for adults (18+) diagnosed with a serious mental illness. We primarily see adults diagnosed with:

- Schizophrenia
- Bipolar Disorder
- Schizoaffective Disorder

Please call our Admissions Department with any questions regarding eligibility or to check the status of your application.

Court orders are not necessarily a guarantee of acceptance into our program. All applicants must be approved by our Admissions Committee which consists of our CEO, COO, CCO, Admissions Director, Director of Nursing, and our Medical Director.

Applicants must also provide income and asset verification in order to qualify for coverage and housing. All admissions must be assessed and tiered by one of the four Arkansas PASSEs.

Birch Tree Communities, Inc. is not an emergency/crisis/acute care facility. If you or a loved one needs immediate help, please call 911 or visit your nearest emergency department for help.

How do I get the process started and what do I need?

Make sure you have the following before pursuing the Admissions Process:

- 1. Patient's Name
- 2. Social Security Number
- 3. Date of Birth
- 4. Proof of US Citizenship
- 5. Property ownership (this affects HUD eligibility)
- 6. Bank account info (this affects HUD eligibility)
- 7. Tiered, and assigned to a PASSE (Only clients assigned to Tier 2 or Tier 3 are eligible for admission.)

Once you have this information, send the initial Referral Form to the Admissions Department via fax or email.

Before the individual is presented to the Admissions Committee, we will also want to see a medication list, a psychiatric evaluation, and some form of treatment history/participation via progress notes

Birch Tree Communities, Inc. cannot accommodate the treatment needs for applicants requiring:

- Skilled Nursing Programs
- Waiver Services
- Sex Offender Registration



Birch Tree Communities, Inc.

Initial Referral Form

Send to: Sarah Testa, LCSW, Admissions Director 501-303-3109 office | 501-631-3794 fax sarah.testa@birchtree.org

Date of Referral	Name of Person Making the Referral	Agency/Hospital/Relation	n to Client Phone #
Client/Patient Info			
-ull Name:			
First	Middle	Last	
OOB:	SS#:	Gender:	Race:
otal Monthly Inco	me: \$ Source of Income (SSI,	SSDI, VA Benefits) with amou	nts:
Client/Patient cons	ents that Birch Tree Communities, Inc. will	become his/her payee: □ YE	S 🗆 NO
Marital Status:	Education: □ GED □ High Sch	nool Diploma □ Some College	□ College Graduate
		is member of Birch Tree Com	
s cheffe a legal 65 c	atizetti il 123 il 140	is member of birth free com	municies, me.: 🗆 123 🗆 NO
Primary Diagnosis			
Secondary Diagnosi	is		
Is the client assigne	ed to a PASSE? YES NO/Unsure		
S		SE Name	Tier Level
f NO/Unsure, has a	in Optum Assessment been requested? \Box ${}^{\backprime}$	YES □ NO	
Where has client so	ought Mental Health treatment?		
s Client on any typ	e of court order? \square YES \square NO If yes, what	type?	
Does the client have	e a legal guardian? □ YES □ NO If yes,		
35 3.12 3.13.13		Phone Number	
Door the client have	e a bank account? □ YES □ NO If yes, what	hank?	
	e a bank account? I YES I NO II yes, what eligible, we'll need access to six months of		
Does the client owr	n any property (home, vehicle, land)? 🗆 YES	S □ NO	

With this form, also send:

- Psychiatric evaluation
- Medication List
- Any progress notes you have
- Labs
- Copy of Court Order

- Copy of Guardianship
- Copy of history & physical
- Release of Information sheet



Birch Tree Communities, Inc.

Release of Information

l,,	,		
Client's Name	Date of Birth	SS #	
Authorize Birch Tree Communities, Inc. to obtain Info	rmation from <i>The</i>	Social Security Administration, my Current and	
and family members (list name(s), Phone Number(s), address(s))			
for the purpose of obtaining information including, bu	ut not limited to:		
Psychiatric evaluation	•	Progress Notes	
 Benefit information and eligibility 	•		
MAR or Medication List	•	Aftercare/Discharge Summary	
Mental Health evaluation	•	Face Sheet/Demographic Information	
 Treatment Plan(s) 	•	 Psychotherapy Notes 	
 Presence/Participation in Treatment 	•	Verbal/Written Communication	
ı	□ YES □ NO		
Client's Printed Name	Date of Birth	SS#	
Individual or Guardian Signature		Date	
Witness Signature if needed		Date	

Transmission Unless otherwise specified, Birch Tree Communities, Inc. reserves the right to disclose information as permitted by this authorization in any manner that is deemed to be appropriate and consistent with applicable law, including, but not limited to: verbally, in paper format, and/or electronically

Sensitivity I am aware that my records may contain sensitive information regarding my mental health, alcohol/substance use, and health diagnoses including HIV/AIDS, and other communicable diseases. I am aware this form is regulated by the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2. The handling of my health information is also regulated by the Health Insurance Portability & Accountability Act, 45 CFR Parts 160 & 164.

Re-Disclosure This authorization does not give permission to re-disclose my information to other organizations without my express permission. I am aware that there are certain federal exceptions to redisclosure in which my information may be distributed for coverage, legitimate legal inquiries, or to address a genuine medical emergency

Right to Decline I am aware of my right to decline signing this form. I understand that my treatment will not be conditioned on my authorization unless medically necessary.

Right to Revoke I understand that I have the right to revoke my authorization in writing at any time by sending a written notification to Birch Tree Communities at the address listed below.